

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **MANI TEHRANCHI, M.D.**

4 Holder of License No. 21210
5 For the Practice of Allopathic Medicine
6 In the State of Arizona

Case No. MD-13-1087A

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR LETTER OF
REPRIMAND**

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 August 6, 2014. Mani Tehranchi, M.D. ("Respondent"), appeared before the Board for a
9 formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H).
10 Respondent was represented by Attorney Andrew Plattner. After due consideration of the
11 facts and law applicable to this matter, at its meeting on October 1, 2014, the Board voted
12 to issue the following Findings of Fact, Conclusions of Law and Order.

13 **FINDINGS OF FACT**

14 1. The Board is the duly constituted authority for the regulation and control of
15 the practice of allopathic medicine in the State of Arizona.

16 2. Respondent is the holder of license number 21210 for the practice of
17 allopathic medicine in the State of Arizona.

18 3. The Board initiated case number MD-13-1087A after receiving a report from
19 a hospital that it temporarily restricted Respondent's obstetrical privileges (August 23,
20 2013 – September 12, 2013). The restriction was implemented based on an incident
21 involving Respondent's alleged failure to perform a physical examination prior to operating
22 on a 20 year-old female patient ("JG").

23 4. JG was seen in Respondent's office on June 20, 2013. Based on her stated
24 last menstrual period at that time, her estimated date of conception was October 13, 2013,
25 which would have made her 23+ weeks gestation on that date. An examination and

1 ultrasound revealed a 16+ week gestation with an estimated date of conception of
2 December 3, 2013.

3 5. JG presented to the hospital with contractions on August 14, 2013 and was
4 seen again two days later. The nursing intake noted a 36 week gestation based solely on
5 JG's and her mother's report. The nurses contacted Respondent and he instructed them to
6 prepare JG for a repeat cesarean section based on this information. His office notes were
7 sent over prior to the procedure.

8 6. When Respondent arrived at the hospital, JG was in the operating room
9 prepped for a cesarean section. According to Respondent, after initiating the procedure he
10 felt the uterus was very small. Upon delivery of the infant, the neonatologist was informed
11 that resuscitation would be in order. An evaluation after the delivery indicated that the
12 infant was 23-24 weeks gestation, which was consistent with the ultrasound done on June
13 20, 2013. The infant was non-viable with eyelids noted to be fused.

14 7. The Medical Consultant (MC) stated that considering JG presented at a
15 reported 36 weeks gestation with a cervix that was LTC, tocolysis should have been
16 considered until further evaluation could be conducted. In addition, the MC stated that JG's
17 history of having used OCs for five months of the pregnancy and that she had received
18 tocolysis in Mexico shortly before presenting, should have caused the staff and
19 Respondent to question the dates and review the information obtained at her June 20,
20 2013 office visit.

21 8. With regard to the allegations, the MC observed that there is a history and
22 physical documented in the chart, but that it is not dated or timed. The MC noted as well
23 that there is no evidence that a history and physical were performed before the cesarean
24 section. The MC stated that Respondent's failure to examine JG and her records prior to
25

operating led to the performance of an elective repeat cesarean section at 23-24 weeks gestation and resulted in the delivery of a non-viable infant.

9. The standard of care when a patient presents with contractions requires that an evaluation be performed to determine whether the patient is in labor which in turn requires a physician to, depending on the gestational age, render appropriate treatment.

10. Respondent deviated from the standard of care by failing to evaluate the patient prior to performing an elective cesarean section at 23-24 weeks gestation.

11. The Board noted the following mitigating factors: 1) the number of other health care professionals who were responsible for the care and treatment of MC; and 2) Respondent's efforts to effect the appropriate changes at the hospital such as implementing better triage policies, providing better access to patient records and requiring mandatory physician evaluations of the preoperative patients.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after

1 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
2 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

3 Respondent is further notified that the filing of a motion for rehearing or review is
4 required to preserve any rights of appeal to the Superior Court.

5 DATED AND EFFECTIVE this 3rd day of October, 2014.

6 ARIZONA MEDICAL BOARD

7
8 By Patricia E. McSoley
9 C. Lloyd Vest, II Acting
Executive Director Interim
Executive
Director

10 EXECUTED COPY of the foregoing mailed
11 this 3rd day of October, 2014 to:

12 Andrew Plattner
13 Sherman & Howard, LLC
14 7033 East Greenway parkway, Suite 250
15 Scottsdale, Arizona 85254
Attorney for Respondent

16 ORIGINAL of the foregoing filed
17 this 3rd day of October, 2014 with:

18 Arizona Medical Board
19 9545 E. Doubletree Ranch Road
20 Scottsdale, AZ 85258

21 Board Staff
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